Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held on June 6, 2007 and June 7, 2007
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Patrick N. Connell, M.D.
Dan Eckstrom
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia Griffen
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G.

Call to Order
The meeting was called to order at 9:30 a.m.

Roll Call
The following Board Members were present: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Members were not present: Patricia R.J. Griffen and Paul M. Petelin, Sr., M.D. The Board had a quorum.

Call to Public
Mr. Dan Cavett spoke during the call to public on behalf of his client, Dr. Rajim Bhatt. Dr. Goldfarb stated that he knew Mr. Cavett and Dr. Mackstaller recused herself when the Board takes up this matter. Mr. Cavett addressed the Board regarding Dr. Bhatt's recent application for a license. Mr. Cavett gave the Board a brief overview of Dr. Bhatt's medical background and training and his license application be granted. Mr. Cavett requested the Board ask Dr. Bhatt to meet with them at their next scheduled Board Meeting.

All other statements issued during the call to public appear beneath the case referenced.

Executive Director's Report

Agency Office Reports

Timothy Miller, J.D., Executive Director informed the Board that the Agency's Licensing Office has been consistent in processing licenses. Mr. Miller informed the Board that Staff is averaging 300 open cases and the average time to complete a case is about 100 days. Mr. Miller pointed out that because of the number of physician accepting consent agreements and the extra one day Board meeting in May, the number of cases awaiting a Board meeting has significantly decreased.

Arizona Medical Board Weekly Legislative Report

Mr. Miller provided an update the status of bills that the Board has monitored closely. The Board discussed Senate Bill 1015 which requires emergency department staff to cooperate with law enforcement. Dr. Connell expressed concern that the law might conflict with HIPAA and patient's privacy rights and that it would place ED staff in a difficult situation.

Discussion of Executive Director's Plan for Reducing Formal Hearing Case Backlog

Mr. Miller provided an overview of the number of cases currently pending formal hearing. Dr. Krishna felt the Board needed to be more proactive in getting cases to hearing faster. Dr. Connell agreed and expressed concern that the Board may have liability for the cases awaiting a formal hearing for Revocation. Mr. Miller stated that the agency has received favorable responses from the Governor's Office of Strategic Planning and Budgeting (OSPB) and the Joint Legislative Budget Committee (JLBC) to obtain a special allocation to hire outside counsel. He estimated the agency would need approximately $330,000 over a three-year period to obtain sufficient outside legal services. Mr. Miller emphasized that OSPB and JLBC had stated that the Board needs a plan for reducing the backlog and a plan that addresses the reasons for the backlog. Mr. Miller explained to the Board that part of the plan would involve dividing legal duties between the litigators and the legal advisor based upon whether the Board was seeking case specific advice or general legal advice. Dr. Martin asked how this new process would affect the legal advice provided to the Board through the Solicitor General's Office. Mr. Miller explained that the Board's Legal Advisor would not be involved with providing Staff specific case advice. Board Members expressed concern that changes that affected the legal advisors legal advice would have a detrimental impact on the Board. The Board requested that the Executive Staff work with the Board's Officers to further develop a solution and make a recommendation to the Board.

MOTION: Dr. Connell moved to refer the matter to the Executive Officers to make recommendations to the full Board.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Chair's Report

Dr. Martin presented a plaque to Mark Nanney, M.D., Chief Medical Consultant, in recognition of his services to the Board for the last two years. Dr. Martin thanked Dr. Nanney for his services to the citizens of Arizona and stated it has been a privilege working with him. Dr. Nanney thanked the Board and stated this was the best job he has ever had.

Dr. Martin also presented a plaque to Dr. Connell for his service as a Board Member for the last ten years. Dr. Martin stated he has known Dr. Connell for a long time and Dr. Connell is, in large part, responsible for Dr. Martin being on the Board. The Board experienced a lot of turmoil over the years and Dr. Connell's leadership has helped develop the Board into what it is now. Dr. Martin wished Dr. Connell well.

Dr. Connell addressed the Board and stated that it has been a great privilege to serve on the Board. He reminisced on how far the Board has come in terms of its professional staff and leadership and excellent legal advice. He is proud of how the Board has developed the Monitored Aftercare Program for physicians with substance abuse problems and created a safe environment for physicians to self report their problems. Dr. Connell was proud of the Disciplinary Rules and remembered how there were none when he first started on the Board. Dr. Connell stated that he was also proud of the Physician Health Program and wants to see it further developed and expanded.

Consideration and Adoption of Amended Office Based Surgery Rules

Dr. Martin stated that the Office Based Surgery (OBS) Subcommittee met telephonically last week, reviewed stakeholder comments and made several changes based upon the comments. Dr. Martin explained that since the Board approved the wording of the prior OBS Rules the changes needed to return for the Board's approval. Drs. Krishna and Lee approved the revised OBS Rule language. Mr. Miller informed the Board that the Rules would be sent back to the Secretary of State to republish and the agency would host another oral comment period.

MOTION: Dr. Connell moved to accept the Office Based Surgery Rules as amended.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Martin noted that this has been a large undertaking by the Board and Staff and thanked Staff for doing it so timely.

Approval of Minutes

MOTION: Dr. Pardo moved to accept the March 26, 2007 Emergency Summary Action Meeting Minutes, the April 11-12, 2007 Regular Session Meeting Minutes, Including Executive Session, and the April 19, 2007 Summary Action Meeting Minutes, Including Executive Session.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Dr. Lee moved to accept the Advisory Letters on item #s 1, 2, 3, 5, 6, 7, 9, 10, 12, 13, 14, 16, 17, 19, 20, 22, 23, 24, 25, and 26.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0892A	L.A.	INAYAT M. ALI-KHAN, M.D.	12985	Advisory Letter for failure to obtain records from neurologist prior to prescribing and continuing to prescribe to a known active drug user.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0533A	AMB	CHARLES S. GANNON, M.D.	6156	Advisory Letter for failure to timely address corneal edema.

Dr. Mackstaller recused herself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0758A	J.G.	JAMES R. BOYED, M.D.	13616	Advisory Letter for inappropriate records.
4.	MD-06-0456A	BANNER ESTRELLA MEDICAL CENTER	MICHAEL R. ROLLINS, M.D.	30379	Invite for a formal interview.

Dr. Goldfarb pulled this case for further discussion. He wondered if the outcome would have changed if the patient had been re-explored when he returned to the emergency room. He also questioned why Staff recommended an Advisory Letter in this case. William Wolf, M.D., Medical Consultant stated that initially Staff recommended a Letter of Reprimand. However, after reviewing Dr. Rollins' statutory response, Staff found mitigating factors and changed its recommendation to an Advisory Letter.

Drs. Goldfarb, Krishna and Connell discussed whether the presence of free air would mandate returning the patient to the operating room and agreed that they would like to invite Dr. Rollins for a formal interview.

MOTION: Dr. Goldfarb moved to reject the Advisory Letter and invite the doctor for a formal interview.
SECONDED: Dr. Connell

Dr. Krishna spoke against any disciplinary action; however, he felt that the Board should have Dr. Rollins in for a formal interview. Dr. Lee stated that the Board had issued an Advisory Letter for a similar case not too long ago. Dr. Connell noted that each case is unique.

VOTE: 9-yay, 1-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0645A	J.G.	CHUBA B. ONONYE, M.D.	23372	Advisory Letter for signing predated prescriptions.
6.	MD-06-0787A	AMB	PAUL N. RICHMANN, M.D.	22915	Advisory letter for prescribing without first conducting a physical examination or having previously established a doctor-patient relationship and for failure to maintain records documenting his prescribing of Hydrocodone.
7.	MD-06-0787B	AMB	STANLEY J. OLIVERIUS, M.D.	16120	Advisory letter for prescribing without first conducting a physical examination or having previously established a doctor-patient relationship and for failure to maintain records documenting his prescribing of Hydrocodone.
8.	MD-06-0251A	AMB	GAIL B. TURNER, M.D.	23529	Advisory Letter for improper monitoring of renal function in a diabetic.

Dr. Goldfarb asked that this case be pulled for discussion. Dr. Sems summarized the case and explained Staff's reasoning for recommending an Advisory Letter.

MOTION: Dr. Goldfarb moved to accept the Advisory Letter.
SECONDED: Dr. Mackstaller
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-06-0776A	AMB	RICHARD O. GRITZMACHER, M.D.	4633	Advisory Letter for action taken in another state for prescribing without first establishing a doctor-patient relationship and for prescribing for other than therapeutic purpose. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
10.	MD-06-0589A	AMB	DANIEL V. MANZANARES, M.D.	24243	Advisory Letter for poor charting and for failure to ensure timely biopsy of a suspicious lesion.

Dr. Manzanares spoke during the call to public. He was in full agreement with the Advisory Letter and he has enrolled in a medical recordkeeping course.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-06-0777A	AMB	ANDREW P. SMITH, M.D.	28031	Invite for a formal interview.

Dr. Smith was present along with his legal counsel, Mr. Rick Delo, and spoke during the call to public. Dr. Smith gave a brief overview of his medical background. He did not dispute any of the Board's findings in this case and admitted that he erred in his recordkeeping. Mr. Delo stated that the Board needed to look at the patient's clinical picture when considering this case.

Dr. Schneider pulled this case for discussion due to the Physician's statements during the call to public. Dr. Wolf summarized the case for the Board. Dr. Krishna expressed concern if Dr. Smith could have changed the patient's outcome.

MOTION: Dr. Schneider moved to reject the Advisory Letter and invite the physician for an interview.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-06-0510A	A.C.	WILLIAM H. NOLAND, M.D.	17808	Advisory Letter for failure to re-evaluate a patient for chronic seizure disorder before initiating treatment. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
13.	MD-06-0629B	AMB	WILLIAM D. MARTZ, M.D.	23543	Advisory Letter for failure order imaging to locate an IUD after imaging showed the IUD was not in the uterus and there was no history of expulsion. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
14.	MD-06-0449A	AMB	STEPHEN GLOUBERMAN, M.D.	8891	Advisory Letter for failure to adequately view the cecum during a colonoscopy.
15.	MD-06-0503A	AMB	RAJEN D. DESAI, M.D.	31618	Advisory Letter for inadequate medical records. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

Dr. Goldfarb pulled this case for further discussion. Board members expressed their concern for Dr. Desai's thinking process and his decision to do an intervention. The Board tabled the matter for discussion the next day.

The Board discussed this case again on Thursday, June 7, 2007 and Dr. Mackstaller commented that after looking at the report, Dr. Desai's decision to do an intervention did not rise to the level of discipline.

MOTION: Dr. Connell moved to issue the physician an Advisory Letter.
SECONDED: Mr. Eckstrom
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-06-0676A	AMB	CATHARINE S. CESAL, M.D.	27115	Advisory Letter for failure to order baseline renal function studies. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
17.	MD-06-0685A	AMB	RONALD S. FISCHLER, M.D.	11577	Advisory Letter for failure to order baseline renal function studies and for inadequate medical records. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.
18.	MD-06-1011A	P.K.	JAMES B. ROSS, M.D.	9584	Advisory Letter for failure to confirm that a suspicious lesion was indeed cancerous. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee. Issue an Order for 20 hours non-disciplinary CME in recordkeeping.

Dr. Pardo pulled this case to discuss Staff's recommendation for an Advisory Letter. She noted that Dr. Ross had two previous Advisory Letters for similar issues. Dr. Nanney stated that Staff made a judgment call and felt that it was mitigating that he has made changes to his practice.

MOTION: Dr. Schneider moved to accept the Advisory Letter with 20 hours non-disciplinary CME in recordkeeping.
SECONDED: Dr. Pardo
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-06-0434A	G.H.	HENRY J. SCHULTE, M.D.	12400	Advisory Letter for failure to document his reason for not providing the patient his medical records. The violation is a minor or technical violation that is not of sufficient merit to warrant disciplinary action.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-06-0674A	AMB	MARC J. STAMAN, M.D.	12163	Advisory Letter for failure to review the correct labs and is a one-time technical error.
21.	MD-06-0947A	AMB	JOHN B. CARSON, M.D.	15263	Advisory Letter for failure to timely anticoagulated a patient. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.

Dr. Krishna stated that he knows Dr. Carson, but it would not affect his ability to adjudicate the case. This case was pulled because the Board questioned whether this patient's outcome would have been different if he had been anticoagulated in a timely manner. Gerald Moczynski, M.D., Medical Consultant, gave the Board a brief overview of the case and stated that the patient's obesity was a mitigating factor.

MOTION: Dr. Goldfarb, M.D. moved to accept the Advisory Letter.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-07-0118A	AMB	STEVEN I. DAHL, M.D.	14605	Advisory Letter for prescribing without a doctor-patient relationship and failure to keep adequate records. While there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
23.	MD-06-0515A	C.W.	JAMES L. ROBROCK, M.D.	16209	Advisory Letter for failure to provide the patient with her medical records in a timely fashion.
24.	MD-06-0779A	D.H.	BRIAN C. ANDREWS, M.D.	27675	Advisory Letter for failure to provide records in a timely manner.
25.	MD-06-0883A	M.S.	L. STAFFAN PETTERSSON, M.D.	26390	Advisory Letter for failure to timely address weight loss and failure to enunciate a plan for anemia and PSA.
26.	MD-06-1010A	S.S.	PAUL F. O'NEILL, M.D.	22764	Advisory Letter for recommending treatment based upon another patient's x-ray.

Dr. O'Neill spoke during the call to public. He accepted responsibility for the error in placing the wrong documentation in this patient's chart. He stated that his office has switched to electronic charts and he has hired additional staff to ensure proper review of patient charts.

ADVISORY LETTERS WITH CME

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0989A	E.V.	SHEILA R. MANE, M.D.	27651	Issue Advisory Letter for inadequate medical records. Issue an Order for 10 hours non-disciplinary CME in medical recordkeeping.

MOTION: Dr. Lee moved to accept the Advisory Letter with 10 hours non-disciplinary CME in recordkeeping.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

REVIEW OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0480A	B.K.	MICHAEL CAMPION, M.D.	16283	Uphold ED Dismissal

BK spoke during the call to public. After his cataract surgery, he no longer has useful vision in his right eye. He encouraged the Board to educate doctors in the human factors in their practice.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0582A	E.C.	CHRISTOPHER P. BEAUCHAMP, M.D.	22021	Uphold ED Dismissal

EC was present along with patient JC. Both EC and JC spoke during the call to public. EC stated that if Dr. Beauchamp did not do anything wrong, her father would not be in a wheelchair today. He was walking before the surgery with the assistance of a cane, and now he has to stop because of the pain.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION

3.	MD-06-0569A	L.B.	PAUL NAKAZATO, M.D.	21265	Uphold ED Dismissal

LB spoke during the call to public. LB stated that the complaint does not concern Dr. Nakazato's technical skills as a surgeon, but rather with his communication skills. LB stated that Dr. Nakazato repeatedly failed to obtain an informed consent and he ignored LB's efforts to contact him postoperatively.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0830A	C.A.	ANDREW M. WOLIN, M.D.	14883	Uphold ED Dismissal
5.	MD-06-0649A	T.S.	WESLEY J. JOHNSON, M.D.	26379	Uphold ED Dismissal
6.	MD-06-0649B	T.S.	PAUL T. SUTERA, M.D.	21975	Uphold ED Dismissal
7.	MD-06-0756A	G.F.	CHRISTOPHER N. COMPTON, M.D.	34117	Uphold ED Dismissal

MOTION: Dr. Krishna moved to uphold the ED dismissals #1-7.
SECONDED: Ms. Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

OTHER BUSINESS

MOTION: Dr. Krishna moved to accept Other Business items #1, 3, 4, 5, 9, and 11.
SECONDED: Ms. Proulx
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0355A	APS	MARK S. WEIS, M.D.	33546	Accept proposed consent agreement for Letter of Reprimand for failure to appropriately manage an alcoholic with depression and failure to maintain adequate patient records. One year Probation - shall attend PACE record keeping course within six months and provide proof of attendance. CME hours shall be in addition to hours required for the biennial review of license. Probation shall terminate upon successful completion of PACE record keeping course.
2.	MD-05-0664A	AMB	MICHAEL A. EPSTEIN, M.D.	9945	Accept proposed consent agreement for Letter of Reprimand for failure to timely diagnose and treat status epilepticus and for making a false or misleading statement to the Board.

Dr. Connell recused himself from this case.

Dr. Pardo pulled this case for discussion to question whether the Board should require CME in ethics. Dr. Nanney summarized the case for the Board. He explained that Staff made a judgment call in this case when negotiating the consent agreement about whether or not they could prove Dr. Epstein made a false statement.

MOTION: Dr. Pardo moved to accept the proposed consent agreement.
SECONDED: Dr. Lee
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member was recused: Dr. Connell. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0258A	AMB	DAVID A. RATH, M.D.	17545	Accept proposed consent agreement for twelve months Suspension to complete a Board approved treatment program within twelve months and if he does not comply, the case will be referred for Revocation. Upon completion of the approved treatment program he shall be placed on Probation for five years with MAP terms.
4.	MD-05-0652A	C.R.	FERNANDO CRUZADO, M.D.	30961	Accept proposed consent agreement for Letter of Reprimand for failure to appropriately diagnose and

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					treat discoid lupus, for altering medical records and failure to maintain adequate medical records. One year Probation with CME in record keeping and ethics.
5.	MD-06-0443A	AMB	DONALD F. STONEFELD, M.D.	14712	Accept proposed consent agreement for Letter of Reprimand for an action taken by another board supported by evidence of a boundary violation with one patient.
6.	MD-06-0770A	AMB	MARK R. HEMPHILL, M.D.	24566	Accept proposed consent agreement for five years probation with MAP terms.

Dr. Goldfarb pulled this case for discussion. Kathleen Muller, Monitored Aftercare Program (MAP), summarized the case for the Board.

MOTION: Dr. Goldfarb moved to accept the proposed consent agreement.
SECONDED: Mr. Eckstrom
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-06-0612A	S.L.	ARNOLD H. MEYEROWITZ, M.D.	13263	Accept proposed consent agreement for Letter of Reprimand for failure to appropriately manage an alcoholic with depression and failure to maintain adequate patient records. One year Probation - shall attend PACE record keeping course within six months and provide proof of attendance. CME hours shall be in addition to hours required for the biennial review of license. Probation shall terminate upon successful completion of PACE record keeping course., Double check this language.

Dr. Pardo pulled this case for discussion to clarify whether Staff intended Dr. Meyerowitz to undergo a PACE evaluation or to take the PACE recordkeeping course. Carol Peairs, M.D., Medical Consultant, summarized the case for the Board. The Board agreed that the wording of the consent agreement should be changed to reflect that the physician must take the PACE recordkeeping course and the credits will not be included in the total number of CME hours required for license renewal

MOTION: Dr. Pardo moved to accept the consent agreement as amended to include the CME wording.
SECONDED: Dr. Lee

The Board clarified that if he declines the wording of the amended consent agreement then he will be invited for a formal interview.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-0683A	AMB	MALCOLM G. WILKINSON, M.D.	21001	Accept proposed consent agreement for Letter of Reprimand for failing to appropriately perform a laparoscopic cholecystectomy and failing to correct all of the patient's injuries during the second operation. Fifteen Years Probation with Practice Restriction from general surgery.

Dr. Goldfarb pulled this case to discuss the length of time it took this case to get to the Board Members. Tina Geiser, Case Manager, explained to the Board Members that staff received notification from the National Practitioner's Databank as a result of a malpractice settlement and began the investigation upon receipt of that notification. Dr. Goldfarb was concerned that the physician was having a lot of problems and should not have been performing surgery. He asked the Executive Director look at the case to see if the Board should have done something differently. Mr. Miller stated that if it was the Board's pleasure, this topic could be placed on a future agenda for discussion.

MOTION: Dr. Goldfarb moved to accept the proposed consent agreement.
SECONDED: Dr. Connell
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-06-0432A	R.B.	THOMAS J. GROVES, M.D.	5104	Accept proposed consent agreement for Letter of Reprimand for failure to properly perform a cervical translaminar epidural steroid injection and for failure to properly sedate a patient during the procedure.
10.	MD-05-1052A	AMB	LEWIS M. SATLOFF, M.D.	17470	Reject proposed consent agreement and Offer the Physician and Consent Agreement for a Letter of Reprimand for violating a Board Order and Five Year Probation with MAP terms.

Dr. Pardo pulled this case for discussion. Mr. Brekke briefly summarized the case for the Board. The consent agreement was drafted to coincide with the monitoring Order Dr. Satloff is currently under in California. Dr. Pardo stated that when there is a violation of Board Order the Board usually issues a Letter of Reprimand. Dr. Krishna agreed and requested Mr. Brekke counteroffer a Letter of Reprimand and Probation.

MOTION: Dr. Krishna moved to reject the proposed consent agreement and offer the physician a Letter of Reprimand for violating a Board Order and five year Probation with MAP terms.
SECONDED: Dr. Pardo
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-06-0935A	AMB	ASLAM PERVEZ, M.D.	35476	Accept proposed consent agreement for a Letter of Reprimand for prescribing controlled substances to an immediate family member; for prescribing non-controlled substances to an immediate family member without conducting a physical examination and for failing to maintain adequate medical records on a patient.
12.	MD-06-0945B	AMB	ROBERT VAVRICK, M.D.	14500	Accept proposed consent agreement for Letter of Reprimand for failure to order a head CT and lumbar puncture for a patient with altered level of consciousness and acute headache.

Dr. Pardo pulled this case and questioned whether the date listed in the consent agreement was correct. Staff informed Dr. Pardo that the change was already made and the physician verbally accepted the change.

MOTION: Dr. Pardo moved to accept the proposed consent agreement.
SECONDED: Dr. Goldfarb
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Dr. Krishna moved to accept the Findings of Fact, Conclusions of Law and Order for items #13, 15, 16, 17 and 18.
SECONDED: Dr. Lee
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-06-0129A	L.S.	GEORGE SEIN, M.D.	13863	Accept draft findings of fact, conclusions of law and order for a Letter of Reprimand for failure to communicate to the patient the results of an abnormal laboratory test delaying the diagnosis of prostate cancer.
14.	MD-05-0263A	J.K.	SCOTT C. FORRER, M.D.	19296	Accept draft findings of fact, conclusions of law and order for a Letter of Reprimand for failure to perform an adequate history and physical examination and for performing unnecessary EMG and nerve conduction testing related to the reason for a patient's neurology consultation.

Dr. Goldfarb recused himself from this case.

Dr. Forrer was present along with his legal counsel, Mr. Bryan Murphy, and spoke during the call to public. He stated that the findings of fact in this case repeatedly recite that the patient was referred to him by her primary care physician. He stated that the patient referred herself to him

and he had no referral from another physician. Mr. Murphy noted that the Board's disciplinary rules specify that a physician may be issued an Advisory Letter for a one time occurrence and asked that the Board change its Order from a Letter of Reprimand to an Advisory Letter.

Ms Cassetta informed the Board she had reviewed the record and consulted with a Board Medical Consultant. Based on that review she asked the Board to accept the Draft with the findings amended to reflect there was no referral to Dr. Forrer.

MOTION: Dr. Connell moved to accept Draft Finding of Fact, Conclusions of Law and Order as amended.
SECONDED: Dr. Lee
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-05-0923A	E.G.	ROBERT C. TEAGUE, M.D.	3925	Accept draft findings of fact, conclusion of law and order for a Letter of Reprimand for failing to maintain adequate records on a patient and for failing to furnish his entire patient record as ordered by the Board.
16.	MD-05-0988A	H.C.	WILLIAM H. CASTRO, M.D.	18402	Accept draft findings of fact, conclusions of law and order for a Letter of Reprimand for failure to personally evaluate prior to delivery a VBAC patient induced with prostaglandin gel and for inadequate medical records.
17.	MD-05-0721A	AMB	FELIPE A. CECENA, M.D.	15243	Accept draft findings of fact, conclusions of law and order for a Decree of Censure for failure to timely see a critically ill patient, for making false and misleading statements in the medical record and to the hospital, and for inadequate medical records. One Year Probation – shall obtain 10 hours CME in ethics. Probation to terminate upon completion of the CME.
18.	MD-06-0047A	J.P.	DARRELL J. JESSOP, M.D.	23441	Accept draft findings of fact, conclusions of law and order for a Letter of Reprimand for improper methadone dosing and improper management of accidental opiate overdose. One Year Probation – shall obtain 10 hours Category 1 CME in pain management, including diagnosis and treatment, with random chart reviews to ensure CME is applied.
19.	MD-06-0293A	M.S.	RAMACHANDRA N. RAO, M.D.	25615	Deny the motion for rehearing or review

Dr. Rao spoke during the call to public. He asked the Board to reconsider the Letter of Reprimand.

Mr. Brekke addressed the Board and stated there was sufficient evidence to support the Board's action.

MOTION: Dr. Goldfarb moved to deny the motion for rehearing or review.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-00-0716	AMB	PETER R. NASH, M.D.	11954	Grant Request for Probation Termination

Ms. Muller summarized the case for the Board. Dr. Nash has been in MAP for over six years and requested termination from the MAP Probation. The staff clarified that the Decree of Censure will remain on the physician's record.

MOTION: Dr. Lee moved to grant the request for Probation termination.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Dr. Krishna moved to refer Other Business items #21 and 22 to formal hearing.
SECONDED: Dr. Connell
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-04-1308A	J.H.	GEOFFREY P. RADOFF, M.D.	9881	Refer to Formal Hearing

Stephen W. Myers and Calvin Raup spoke during the Call to Public in support of Dr. Radoff. Mr. Myers stated the Board agreed that Arizona Homeopathic Board would have primary jurisdiction in this case and the Arizona Homeopathic Board submitted its findings to the Board. They stated that the law required the Arizona Medical Board to make a decision based solely upon a review of the records and the Arizona Medical Board could not conduct a formal interview or refer the matter for a formal hearing.

Ms. Cassetta provided the Board with an overview of the legal issues in this case and addressed Mr. Myers's legal analysis. Ms. Cassetta advised the Board that they had the authority to take a different action than the Homeopathic Board and that they could refer the matter for a formal hearing.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-06-0937A	AMB	JOHN V. DOMMISSE, M.D.	22164	Referral to Formal Hearing

Dr. Connell noted that Dr. Dommisse has several cases awaiting formal hearing for revocation involving similar issues and that one formal hearing has been pending for four years.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-06-0353A	AMB	HARA P. MISRA, M.D.	14933	Uphold ED Referral to Formal Hearing

Dr. Krishna recused himself from this case.

Mr. Peter Fisher, attorney for Dr. Misra, spoke during the call to public. Mr. Fisher asked that the Board review its referral to formal hearing. Dr. Misra would like the Board to give him a chance to present his case to the Board rather than send him to formal hearing for revocation.

MOTION: Dr. Lee moved to uphold the ED Referral to Formal Hearing.
SECONDED: Dr. Connell
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
24.	MD-04-0516A	AMB	SHAHIR Z. ASHAM, M.D.	8174	Rescind Referral to Formal Hearing
25.	MD-05-0549A	AMB	LYNN M. GRUND, M.D.	27605	Rescind Referral to Formal Hearing
26.	MD-04-0924A	AMB	ROBERT L. HERMAN, M.D.	16746	Rescind Referral to Formal Hearing
27	MD-04-1304A MD-04-1005A MD-04-0864A MD-04-0024A MD-05-0208A	L.R. S.F. AMB N.M. AMB	KEVEN D. BROCKBANK, M.D.	29044	Rescind Referral to Formal Hearing
28.	MD-05-0476A MD-06-0455A MD-06-0415A MD-06-0465A	D.W. M.S. K.Y. AMB	HOWARD LEE MITCHELL, M.D.	30004	Rescind Referral to Formal Hearing
29.	MD-04-1163A	AMB	WILLIAM V. GAUL, M.D.	13119	Rescind Referral to Formal Hearing

Mr. Brekke stated a recent Court of Appeals decision involving another State regulatory board states that the regulatory board no longer had jurisdiction over a licensee once that licensee no longer holds a license. The decision allows the Board to close pending complaints against physicians who are no longer licensed and retain the information gathered during the investigation until the individual reapplies for licensure. The information may be considered when determining whether to license a physician and may be used to take disciplinary action if the physician is granted a license. Ms. Cassetta pointed out the decision does not apply to matters where the case is pending when the license is due to expire because the Board has specific statutory authority giving it continuing jurisdiction.

Dr. Lee questioned how other states would be made aware of the Board's findings if the physician applied elsewhere. Mr. Miller informed the Board that the Board would be allowed to disclose this information if queried by another state and the case would be coded in the database so that it is retained permanently and flagged in the future. Mr. Miller also informed the Board that while the case closure would not be reported to the National Practitioner's Data Bank, Board Staff would notify any states where the physician is known to be licensed of the investigative findings.

MOTION: Dr. Goldfarb moved to rescind the referrals to formal hearing for Other Business items #24-29.
SECONDED: Mr. Eckstrom
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Dr. Goldfarb moved to accept the proposed consent agreements for Other Business items #30-33.
SECONDED: Dr. Krishna
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krisha, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
30.	MD-07-0165A	D.S.	MARY E. GROVES, M.D.	30315	Accept proposed consent agreement for Surrender of an active license.
31.	MD-07-0269A	AMB	SHELLEY L. EVERLY, M.D.	28385	Accept proposed consent agreement for Surrender of an active license.
32.	MD-06-0364A	AMB	EMMANUEL G. ACOSTA, M.D.	31245	Accept proposed consent agreement for a Letter of

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					Reprimand for prescribing medications to patients without first performing a physical examination, for failure to maintain adequate medical records on nineteen patients and for actions taken by another medical board.
33.	MD-06-0634A	AMB	JAMES TILLINGHAST, M.D.	14418	Accept proposed consent agreement for Surrender of an active license.

Wednesday, June 6, 2007

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0173A	M.S.	WILLIAM E. MORA, M.D.	13088	Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for inappropriate prescribing and inadequate medical records and for prescribing for non-therapeutic purposes.

Dr. Peairs summarized the quality of care issues in this case for the Board. Dr. Mora deviated from the standard of care by failing to monitor, and follow up on prescribing opioids for chronic pain patients and for failure to recognize aberrant drug seeking behavior. Dr. Mora stated that in the process of prescribing to patient WS, he intended to get him into a pain management clinic. Dr. Krishna led the questioning and noted that Dr. Mora is a Board Certified plastic surgeon. Dr. Mora admitted that he was not paying attention when prescribing WS pain medication. Dr. Mora felt he was passive aggressive with WS and agreed with the Board that it was not correct. Dr. Mora stated that he is now aware of the boundary issues and guidelines when prescribing pain medication. Dr. Mora was unaware that people could be drug seeking with physicians and felt he was too trusting back then. In closing, Mr. Fisher stated that Dr. Mora has come along way in the past sixteen months in terms of understanding problems that he had and the ways in which he needs to deal with them. Dr. Krishna appreciated Dr. Mora's honesty, but stated there was unprofessional conduct.

MOTION: Dr. Krishna moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27)(j)- Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes, A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public, and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Pardo

Dr. Krishna stated that he made the motion because there was actual harm to WS in the amount of pain medication that was prescribed to him.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Dr. Krishna moved for a Draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for inappropriate prescribing and inadequate medical records and for prescribing for non-therapeutic purposes.
SECONDED: Dr. Connell
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-05-1137A	AMB	TROY J. NELSON, M.D.	19324	Refer to Formal Hearing.

Dr. Nelson was present with counsel and co-counsel, Mr. Michael Golder and Mr. John J. Shufeldt. Dr. Nelson was asked to answer the following question: "Please indicate for the record that you understand this interview is not a full evidentiary hearing and by choosing this interview over a formal hearing you have waived the right to a full evidentiary hearing, including the opportunity to question the medical consultant who may have reviewed this case." Dr. Nelson would answer "yes" or "no" and stated he was not willing to waive his right to an evidentiary hearing and his right to cross-examine the medical consultant who might have reviewed this case.

MOTION: Dr. Connell moved to refer this case to Formal Hearing.
SECONDED: Dr. Lee

MOTION: Dr. Krishna moved to enter into Executive Session.
SECONDED: Dr. Goldfarb
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

The Board went into Executive Session at 10:22a.m.
The Board returned from Executive Session at 10:31am.

The Board voted on Dr. Connell's motion to refer the case to formal hearing.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-05-1071B	AMB	MICHAEL D. SAPOZINK, M.D.	20542	Issue an Advisory Letter for improper radiation therapy resulting in brain stem injury. This matter does not rise to the level of discipline.

Dr. Sems summarized the quality of care issues in this case for the Board. Dr. Sapozink deviated from the standard of care by administering an excessive dose of radiation for the size of the collimator used and the expected tolerance of adjacent critical structures. Dr. Sapozink felt that his care in this case was accurate, appropriate and had all of the quality assurance in place. Dr. Goldfarb led the questioning and opined that if Dr. Sapozink was not comfortable in performing the procedure, he should have stopped and gone over the treatment plan with the surgeon. Dr. Sapozink stated that he was comfortable in proceeding with the procedure; he thought he would have received more assistance from the neurological surgeon involved. Dr. Goldfarb noted that Dr. Sapozink did not have a lot of experience performing this type of procedure as he had only done three. Dr. Sapozink did not stop the progression of the case because both the patient and surgeon were anxious to move forward. Dr. Mackstaller noted that Dr. Sapozink did not have any complications of this magnitude in the past. Dr. Krishna felt that the patient's management after sustaining the injury was inappropriate. The Board reviewed the post operative x-rays. Dr. Martin noted that the patient presented for her first follow up appointment, but did not appear for a subsequent follow up visit. Dr. Martin stated that her non-compliance did not afford Dr. Sapozink the opportunity to recognize the complication earlier and intervene.

In closing, Mr. Campbell stated that Dr. Sapozink believes that he was well within the standard of care at the time this occurred. Dr. Goldfarb felt that the team who performed this procedure with Dr. Sapozink did not work well as a team and there was inexperience in performing this procedure. Dr. Goldfarb stated that Dr. Sapozink should have stopped the procedure when he felt he did not have the back up or assistance that he needed.

MOTION: Dr. Goldfarb moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Connell
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Goldfarb stated that Dr. Sapozink was a very careful physician, but noted there were some deficiencies. He also stated they did not know the exact reason for the injury. Dr. Goldfarb recommended an Advisory Letter as he felt the matter did not rise to the level of discipline.

MOTION: Dr. Goldfarb moved to issue an Advisory Letter for improper radiation therapy resulting in brain stem injury. This matter does not rise to the level of discipline.
SECONDED: Dr. Krishna
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-06-0513C	I.R.	QUIRINO B. VALEROS, M.D.	9962	Issue an Advisory Letter for failure to obtain a CT scan or MRI of the brain in a more urgent fashion on the second examination. There is insufficient evidence to support discipline.

IR spoke during the call to the public on behalf of her husband, patient RR. She felt that Dr. Valeros could have saved her husband's life. She claimed RR's healthcare was prejudiced and compromised due to the location of the facility and wondered if his treatment would have been different if he had not been in the prison system. She stated that Dr. Valeros ignored the obvious crisis.

Dr. Valeros was present with counsel, Ms. Margaret Bergin. Dr. Moczynski summarized the quality of care issues in this case for the Board. Dr. Valeros deviated from the standard of care by failing to perform fundoscopic examination to rule out cerebral edema and ordering a computed tomography (CT) scan on an emergent basis. Dr. Valeros extended his sympathy to RR's family. He stated that RR's symptomatology was appropriate for the treatment he delivered and asked that the Board dismiss this case. Dr. Mackstaller led the questioning and noted that Dr. Valeros is not Board Certified. Dr. Valeros informed the Board of the process for ordering a (CT) scan when working in the Department of Corrections (DOC). He stated that an emergent CT scan may not have affected RR's ultimate survival. He also stated that he did not request an emergent CT scan because there was no supporting symptomatology or basic findings to justify the request.

In closing, Ms. Bergin stated that this was an unfortunate outcome, but Dr. Valeros has no control over the health needs system within the prison system. She stated that the attending nurse did not bring the emergent situation to the physician's attention and Dr. Valeros did not have any knowledge of the situation being emergent. She pointed out that Dr. Valeros did order the CT scan the second time RR presented to him. Dr. Valeros stated that he did his best and stated that the prison system is far different from private practice due to security issues. Lorraine Mackstaller, M.D., expressed that being a physician in the DOC is probably more difficult that being in a medical center or private practice. Dr. Mackstaller believes Dr. Valeros acted appropriately in this case.

MOTION: Dr. Mackstaller moved to dismiss this case.

SECONDED: Dr. Lee

Dr. Krishna stated he thought that an Advisory Letter would be more appropriate than dismissal. He noted the hassle Dr. Valeros would have to go through to obtain an emergent CT scan. However, Dr. Valeros should have made the CT scan emergent the second time RR presented to him.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Lee, Mr. Eckstrom, Dr. Pardo, and Dr. Mackstaller. The following Board Members voted against the motion: Dr. Connell, Dr. Goldfarb, Dr. Krishna, Dr. Martin, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 4-yay, 6-nay, 0-abstain, 0-recuse, 2-absent.
MOTION FAILED.

MOTION: Dr. Krishna moved to issue an Advisory Letter for failure to obtain a CT scan or an MRI of the brain in more of an urgent fashion on the second examination. There is insufficient evidence to support discipline.
SECONDED: Dr. Lee

Dr. Martin spoke in support of the motion and stated that considering where this took place, it should be considered to be more of a technical error.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Martin, Ms. Proulx, and Dr. Schneider. The following Board Members voted against the motion: Mr. Eckstrom, Dr. Mackstaller, and Dr. Pardo. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 7-yay, 3-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Dr. Martin stated that he is concerned with the quality of care patients receive in the prison system, they receive suboptimal care. Dr. Martin asked that this be included as a topic for Board discussion during their Offsite Meeting scheduled for September 2007.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0470A	N.J.	SCOTT A. WASSERMAN, M.D.	23328	Letter of Reprimand for failure to provide adequate anesthesia during liposuction and adequately monitor the anesthesia when performing a liposuction procedure and for failure to maintain adequate medical records. One Year Probation to obtain 20 hours of CME in areas of sedation and perioperative documentation. Probation to terminate upon completion of CME.

Dr. Wasserman was present without counsel. Dr. Wolf summarized the quality of care issues in this case for the Board. The standard of care for liposuction is to perform an initial evaluation, discuss options, make recommendations for treatment, provide informed consent, perform the surgery and anesthesia in a technically competent fashion, and provide appropriate follow-up care with proper documentation of all steps in the medical record. Dr. Wasserman deviated from the standard of care by failing to provide adequate anesthesia. NJ experienced extreme pain as a result. Dr. Wasserman also deviated from the standard of care by failing to properly monitor the patient during the performance of liposuction. Dr. Lee led the questioning and asked Dr. Wasserman to give a brief overview of his background and medical training. Dr. Wasserman stated that the training for the type of liposuction he performs is hands-on and is not typically offered in residency or fellowship trainings. Dr. Lee noted the medical record did not adequately reflect what happened in this case and the standard of care requires that the record adequately reflect what happened during a procedure. Dr. Wasserman admitted falling below the standard of care in this respect.

In closing, Dr. Wasserman stated this has been a learning lesson for him. This case does not represent a pattern of behavior that would warrant a Letter of Reprimand and is not representative of how he practices as this was an isolated incident. Dr. Lee stated that the issue is fairly complex and the documentation was so poor that the patient's complaint of significant pain should be taken at face value. He found significant deficiencies within the medical records.

MOTION: Dr. Lee moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Lee stated he appreciated Dr. Wasserman's straightforwardness. However, it seems clear that the patient had more pain than usual in this particular case and that Dr. Wasserman use of template dictations for a postoperative note is unacceptable.

MOTION: Dr. Lee moved to issue an Advisory Letter for failure to provide adequate anesthesia during liposuction and adequately monitor the anesthesia when performing a liposuction procedure and for failure to maintain adequate medical records. Obtain 20 hours of non-disciplinary CME in areas of sedation and perioperative documentation.
SECONDED: Dr. Mackstaller

Dr. Connell and Dr. Krishna spoke against the motion and were in support of a Letter of Reprimand. Dr. Connell was concerned that Dr. Wasserman does not take the matter as seriously as he should.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Mr. Eckstrom, Dr. Lee, Dr. Mackstaller, and Dr. Pardo. The following Board Members voted against the motion: Dr. Connell, Dr. Goldfarb, Dr. Krishna, Dr. Martin, Ms. Proulx and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 4-yay, 6-nay, 0-abstain, 0-recuse, 2-absent.
MOTION FAILED.

MOTION: Dr. Connell moved for a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to provide adequate anesthesia during liposuction and adequately monitor the anesthesia when performing a liposuction procedure and for failure to maintain adequate medical records. One Year Probation to obtain 20 hours of CME in areas of sedation and perioperative documentation. Probation to terminate upon completion of CME.
SECONDED: Dr. Krishna
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Dr. Goldfarb, Dr. Krishna, Dr. Martin, Ms. Proulx and Dr. Schneider. The following Board Members voted against the motion: Dr. Lee, Dr. Pardo, Mr. Eckstrom, and Dr. Mackstaller. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 6-yay, 4-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
6.	MD-06-0467A	J.D.	STEVEN STEINBERG, M.D.	20302	Issue an Advisory Letter for failure to adequately supervise a medical assistant.

Dr. Steinberg was present without counsel. Dr. Schneider stated that she knew Dr. Steinberg but it would not affect her ability to adjudicate the case. Dr Wolf summarized the case for the Board. Dr. Wolf stated that Dr. Steinberg failed to adequately supervise a medical assistant. Vicki Johansen, Case Manager, stated that Dr. Steinberg admitted that there was a lack of communication with the patient.

Dr. Krishna led the questioning. Dr. Steinberg admitted there was a problem with communication between the staff and patients in his office because of the telephone system. At the time this incident occurred, his office fielded about 300 calls per day. JD was advised to call the office with any signs of infection. He did call, but experienced difficulties getting through to Dr. Steinberg; however, there was no documentation that a call from JD was received from his office. After JD was seen by Dr. Steinberg, there was a delay in communicating the laboratory results back to JD. Dr. Krishna questioned how Dr. Steinberg has changed his practice to better communicate with his patients. Dr. Steinberg stated he has a new practice administrator and a new telephone service. His staff has also been prompted to answer calls as they come in and keep better records of the telephone conversations. He apologized to JD for not returning his call and he is trying his best to improve the system. Dr. Pardo asked if there have been other instances where there was a communication breakdown with patients. Dr. Steinberg stated other physicians in his practice have experienced the same issue. Dr. Goldfarb expressed concern about Dr. Steinberg's lackadaisical approach to his post-operative care.

In closing, Dr. Steinberg stated that he apologized to the patient and he is sorry that he lost JD as a patient.

Dr. Krishna stated that he did believe there was not any unprofessional conduct in this case. However, after the interview, it was apparent that there was a lack of communication between Dr. Steinberg and his medical assistant.

MOTION: Dr. Krishna moved to issue an Advisory Letter for failure to adequately supervise a medical assistant.
SECONDED: Dr. Pardo
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Martin, Dr. Pardo, and Ms. Proulx. The following Board Member was opposed: Dr. Mackstaller. The following Board Member abstained: Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 8-yay, 1-nay, 1-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
7.	MD-06-0950A	AMB	MOHAMMAD Z. QURESHI, M.D.	8269	Draft Findings of Fact, Conclusions of Law and Order for Decree of Censure for improper diagnosis and treatment of patients with chronic pain, specifically, the improper use of injections, improper combination of medications, improper procedural pre-medication, inadequate understanding of anatomy and for improper billing. Ten year Probation restricting Dr. Qureshi from performing any pain management-related injection therapies. The physician may petition the Board for termination of Probation upon completion of a PACE evaluation for his global fund of knowledge in anesthesia and with specific emphasis in peripheral nerve blocks, and demonstrating that he has complied with the terms of that evaluation, and further demonstrating to the Board that he is competent to resume pain management related therapies.

Dr. Qureshi was present with counsel, Mr. Stephen W. Myers. Dr. Peairs summarized the case for the Board. Dr. Qureshi deviated from the standard of care by unsubstantiated diagnosis and performance of injections in the absence of recognized indications and with no apparent limit to the number of times a patient is exposed to a dilute although potentially neurotoxic injection. Billing irregularities were also noted. She informed the Board that Dr. Qureshi submitted an article with a Motion for Good Cause. She briefly summarized the article for the Board and then asked the Board to refer to the Motion for Good Cause. She stated that the five year old article is irrelevant to the matter here today, and was typical of the repeated misrepresentation by Dr. Qureshi and his experts.

Dr. Qureshi stated that he thinks Dr. Peairs is misguided about the alcohol neurotoxicity. He briefly educated the Board on muscle spasms and how to treat them.

Dr. Lee led the questioning and asked Dr. Qureshi to explain the type of nerve blocks he uses to address pain concerns. Dr. Lee also questioned the types of patients Dr. Qureshi typically treats and Dr. Qureshi stated that he sees a selective group of patients that are different from the patients seen by other Tucson pain physicians. Dr. Lee questioned Dr. Qureshi about his understanding of anatomy of the nerves in the thigh, hip and arm and Dr. Qureshi's injection treatment. Dr. Lee also questioned the Current Procedural Terminology (CPT) codes Dr. Qureshi used to bill for his services and stated that Dr. Qureshi coded some procedures that were trigger point injections as peripheral nerve injections. Dr. Qureshi admitted his documentation did not support the level of coding for which he billed. Dr. Goldfarb also expressed concern with Dr. Qureshi's coding practices. Dr. Qureshi stated that he has taken 20 hours of continuing medical education in coding and compliance. Dr. Krishna noted that Dr. Qureshi needs to make a diagnosis before administering an injection.

In closing, Mr. Myers stated that Dr. Qureshi has had an unblemished career until 2001 in which he signed a consent agreement with the Board. All three experts used in Dr. Qureshi's defense disagreed with the medical consultant who reviewed this case. They were all in agreement that his practice is safe and effective. Dr. Lee stated there was unprofessional conduct on Dr. Qureshi's part and that his practice was beyond the pale for other practitioners in this field of practice. Dr. Qureshi deviated from the standard of care by performing numerous injections at a single office visit for every symptom listed by the patient. He also felt Dr. Qureshi inappropriately billed for procedures not performed.

MOTION: Dr. Lee moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public, A.R.S. §32-1401 (27)(u) – Charging a fee for services not rendered or dividing a professional fee for patient referrals among health care providers or health care institutions or between these providers and institutions or a contractual arrangement that has the same effect, A.R.S. §32-1401 (27)(v) – Obtaining a fee by fraud, deceit or misrepresentation, A.R.S. §32-1401 (27)(w) – Charging or collecting a clearly excessive fee… and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Connell
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2absent.
MOTION PASSED.

Dr. Lee stated that after the discussion today and the questions asked, he believed these were egregious acts.

MOTION: Dr. Lee moved for a Draft Findings of Fact, Conclusions of Law and Order for Decree of Censure for improper diagnosis and treatment of patients with chronic pain, specifically, the improper use of injections, improper combination of medications, improper procedural pre-medication, inadequate understanding of anatomy and for improper billing. Ten year Probation restricting Dr. Qureshi from performing any pain management-related injection therapies. The physician may petition the Board for termination of Probation upon completion of a PACE evaluation for his global fund of knowledge in anesthesia and with specific emphasis in peripheral nerve blocks, and demonstrating that he has complied with the terms of that evaluation, and further demonstrating to the Board that he is competent to resume pain management related therapies.
SECONDED: Dr. Connell

The Board Members considered the Probationary terms, knowing that it would effectively end Dr. Qureshi's current practice. The Board Members agreed that if Dr. Qureshi could demonstrate through PACE that he was safe to practice injection therapies that he may apply to the Board to resume this practice. The Board agreed not to place a limit on how long Dr. Qureshi would have to wait before applying to the Board and demonstrating his ability to return to this practice. The Board also clarified that the PACE evaluation should consider Dr. Qureshi's global fund of knowledge in anesthesia with specific emphasis in pain management and peripheral nerve blocks.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

Thursday, June 7, 2007

Call to Order
The meeting was called to order at 8:00 am

Roll Call
The following Board Members were present: Patrick N. Connell, M.D., Dan Eckstrom, Robert P. Goldfarb, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Members were not present: Patricia R.J. Griffen and Paul M. Petelin, Sr., M.D.

Call to Public
The statements issued during Call to Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN	LIC.#	RESOLUTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-06-0187A	C.S.	ELA M. TIMBADIA, M. D.	16679	Draft Findings of Fact, Conclusions of Law and Order Letter of Reprimand for failure to abandon the procedure after multiple attempts in the face of possible anatomical abnormalities, and failure to recognize an improperly placed central catheter.

CS and her husband, RS spoke during the call to public. RS stated that Dr. Timbadia should have obtained a consult or delayed the procedure for later that day. CS stated that Dr. Timbadia told her just before the surgery that she has never been sued and she would take very good care of her. She said the main issue is that Dr. Timbadia did not listen to her when she saw her postoperatively.

Dr. Timbadia was present with counsel, Mr. John Drazkowski. Dr. Martin stated that he knows Mr. Drazkowski, but it would not affect his ability to adjudicate the matter. Dr. Moczynski summarized the quality of care aspects of the case for the Board. Dr. Timbadia deviated from the standard of care by attempting to place the catheter for 3.5 hours without abandoning the procedure, by not placing CS' catheter in the correct place and by not recognizing that she placed CS' catheter in the pleural space and; therefore, administered chemotherapy into CS' pleural space on multiple occasions. Ms. Geiser stated that Dr. Timbadia's privileges were restricted, but Dr. Timbadia failed to inform the Board of this on her 2005 license renewal form. Dr. Timbadia stated that some of the comments made by the complainant were untrue. She said she has never told a patient that she has never been sued and that the surgery was not as long as alleged by the complainant. She also stated there were no signs during the surgery that she misplaced the catheter. Dr. Connell led the questioning and confirmed that Dr. Timbadia's training as a general and vascular surgeon and her history of placing central lines.

In this case, Dr. Timbadia explained she had difficulty placing the guide wire because CS had superior vena cava syndrome. Dr. Timbadia attempted to place the line four times before succeeding. Dr. Connell noted it would have been more prudent to stop with the procedure at an earlier time in order to avoid complications. Dr. Connell also addressed Dr. Timbadia's response on her 2005 license renewal form and asked how she could have believed her suspension of privileges to be informal when she was given a formal letter from the hospital summarily suspending her privileges. Dr. Timbadia stated that although she received the letter, she was told by the Chief of Staff that it was an informal way of asking her not to perform central line placements in the future. Dr. Connell noted that the hospital did not rescind its suspension of her privileges until a year after Dr. Timbadia filled out her license renewal application.

In closing, Dr. Timbadia stated that she did the best she could and believed the catheter was placed correctly. She had the backing of three radiologists that the catheter was in the right place. She believed the summary suspension of her privileges was informal and she was told by the Chief of Staff that she did not need to report it to the Board. Mr. Drazkowski referred the Board members to a letter recently submitted by the hospital in support of Dr. Timbadia. He also stated that the medical standard of care is different than the legal standard of care and Dr. Timbadia met the medical standard of care.

Dr. Connell stated that he has several concerns and thinks that subsequent data demonstrates that this catheter was never correctly placed in the central circulation. A physician has the obligation to recognize a complication and try to remedy it. Dr. Timbadia failed to recognize the problem during the surgery and again, one week later, when CS presented with a pleural effusion. Dr. Connell also expressed his concern with the number of times Dr. Timbadia attempted to place the catheter. He noted that Dr. Timbadia still thinks she placed it correctly and that is problematic.

MOTION: Dr. Connell moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public., A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient., and A.R.S. §32-1401 (27)(jj) - Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board.
SECONDED: Dr. Krishna

Dr. Connell explained his reasoning for citing A.R.S. §32-1401 (27)(jj) and noted that any physician whose privileges have been summarily suspended knows that it is a serious matter and believed it had to clearly be on Dr. Timbadia's mind when she filled out her license renewal application. Dr. Mackstaller and Dr. Goldfarb spoke against citing Dr. Timbadia on A.R.S. §32-1401 (27)(jj). Dr. Martin also spoke against citing on this statute because the hospital clearly backtracked on its statement that it was a formal action.

AMENDED MOTION: Dr. Connell moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

MOTION: Dr. Connell moved for a Draft Findings of Fact, Conclusions of Law and Order Letter of Reprimand for failure to abandon the procedure after multiple attempts in the face of possible anatomical abnormalities, and failure to recognize an improperly placed central catheter.
SECONDED: Dr. Schneider
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-05-0761A	M.T.	PAUL R. MAZZARELLA, M.D.	18157	Draft Findings of Fact, Conclusions of Law and Order Letter of Reprimand for inadequate medical records and prescribing medications without appropriate physical examination and laboratory studies, and documented follow-up

Dr. Mazzarella was present with counsel, Mr. Stephen Myers. Dr. Sems summarized the quality of care issues of the case for the Board. Dr. Mazzarella deviated from the standard of care by failing to maintain adequate medical records, by failing to appropriately follow-up and examine patient LM, by prescribing controlled substances to a family member, and engaging in a sexual relationship with a current patient. Dr. Mazzarella stated that he met LM prior to her becoming his patient and began dating her. He admitted his treatment records for LM are incomplete and there are many that are missing. Dr. Mazzarella was aware of the rules and guidelines against prescribing to an immediate family member and stated he did not prescribe to LM after they were married.

Dr. Pardo led the questioning. Dr. Mazzarella stated he is currently aware of the statutes pertaining to dating a patient, but he was not aware of what the laws were when he first started dating LM in 1993. He did not see a problem with dating LM after she became his patient since he was dating her prior. Dr. Mazzarella stated he continued treating LM for some things after they were married and did not find this to be a problem since he also knew her as a patient. He stated he kept medical records on LM, but they cannot be located. These records include laboratory studies he ordered when he prescribed medication to LM. Dr. Pardo questioned Dr. Mazzarella about prescriptions for Vicodin called in for LM under his name. Dr. Mazzarella stated LM called in those prescriptions without his knowledge. Dr. Mazzarella acknowledged it was his responsibility to keep track of the prescriptions written on his pad. Dr. Mackstaller questioned Dr. Mazzarella about his decision to treat a family member and Dr. Mazzarella stated he now knows that it is unethical and that a physician who does this may have a bias or conflict of interest in treating a family member. Dr. Goldfarb stated that it appeared Dr. Mazzarella was still not aware of the Medical Practice Act as it specifically pertains to these issues.

In closing, Mr. Myers stated that Dr. Mazzarella has had an unblemished record as a licensed physician for 18 years. While he agreed with Dr. Pardo that the statute in 1993 prohibited physicians from dating their patients, that statute no longer exists and therefore, cannot be enforced. Dr. Mazzarella did not prescribe controlled substances to LM after they were married and that LM called in those prescriptions without Dr. Mazzarella's knowledge.

Dr. Sems clarified for the record that there were prescriptions written in 2001 and 2002 on Dr. Mazzarella's prescription pad and that these were not called in. Dr. Sems stated that Staff did not get a good answer from Dr. Mazzarella during the investigative process whether it was his signature on the prescription or not. Dr. Martin stated that the Board tries to find specific evidence to support their decisions. However, there are times when the Board sees unusual issues that are concerning. Dr. Martin found it unbelievable that a physician would not have known about so many prescriptions having been called in under his name. Dr. Connell agreed and stated this is especially true when the physician is living with the person who received the medications. Dr. Mackstaller noted that LM attempted to deceive the pharmacist by calling in the prescriptions under her maiden name. Ms. Cassetta informed the Board that Dr. Mazzarella could not be cited for prescribing to a family member prior to his marrying LM because at the time she was not an immediate family member as defined in the statute.

MOTION: Dr. Goldfarb moved to go into Executive Session.
SECONDED: Dr. Krishna
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

The Board went into Executive Session at 10:43 a.m.
The Board returned from Executive Session at 11:00 a.m.

Dr. Mackstaller asked Dr. Mazzarella if he has written prescriptions to LM in the past five years. Dr. Mazzarella stated he wrote prescriptions for medications such as antibiotics, but many of those prescriptions were renewals and he did not keep a medical record. However, her other treating physicians have medical records. Dr. Connell noted Dr. Mazzarella wrote a new prescription for Cipro on March 19, 2006 for which Dr. Mazzarella does not have a corresponding medical record. Dr. Schneider asked what steps Dr. Mazzarella has taken to ensure this does not happen again. He stated that LM is currently monitored by the Nursing Board and is being monitored closely for this.

Mr. Myers noted that the community standard does not require a physician to keep a medical record for a prescription renewal. Dr. Connell stated that from the testimony today, it is clear Dr. Mazzarella prescribed to his wife without keeping an appropriate medical record. Dr. Lee and Dr. Goldfarb disagreed with Mr. Myers's statement that the community standard does not require a medical record for prescription renewals. Dr. Connell added that there is nothing to support Dr. Mazzarella doing an appropriate physical examination or ordering laboratory studies. Another physician would not be able to provide continuing care based upon Dr. Mazzarella's lack of medical records.

MOTION: Dr. Connell moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e) – Failing or refusing to maintain adequate records on a patient and A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Dr. Mackstaller
VOTE: 9-yay, 0-nay, 1-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Dr. Connell moved for a Draft Findings of Fact, Conclusions of Law and Order Letter of Reprimand for inadequate medical records and prescribing medications without appropriate physical examination and laboratory studies, and documented follow-up.
SECONDED: Dr. Lee

Dr. Krishna spoke against the motion and stated he preferred an Advisory Letter instead of a Letter of Reprimand. Dr. Martin also spoke against the motion. Dr. Connell stated that there was a clear pattern, the physician was evasive in his testimony and it is clear there were medications prescribed without a medical record.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Lee, Dr. Mackstaller, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Member voted against the motion: Dr. Krishna. The following Board member abstained: Dr. Martin. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 8-yay, 1-nay, 1-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-05-1180A	C.S.	JOHN C. MORGAN, M.D.	25871	Refer to Formal Hearing.

Dr. Morgan was present with counsel, Mr. Calvin Raup. Dr. Morgan would not indicate that he understood the interview is not a full evidentiary hearing and by choosing the interview over a formal hearing he waived his right to a full evidentiary hearing, including the opportunity to question the medical consultant who may have reviewed his case. Dr. Martin entertained a motion to refer this case to formal hearing.

MOTION: Dr. Mackstaller moved to refer this case to Formal Hearing.
SECONDED: Dr. Connell
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-06-0386A	AMB	REBECCA A. COOK, M.D.	23537	Dismiss

Dr. Cook was present with counsel, Mr. Gordon Lewis. Dr. Moczynski summarized the quality of care issues in this case for the Board. The standard of care requires a physician to monitor levels when prescribing Vancomycin. Dr. Cook deviated from the standard of care by failing to monitor toxicity levels of Vancomycin. Dr. Cook stated that the patient did well clinically and requested discharge while still on antibiotics. She felt that she met her responsibilities and the standard of care in this case. Dr. Connell led the questioning. Dr. Cook briefly explained the antibiotic administered to the patient and the state that the patient was in when he first presented to her. Dr. Krishna stated that as the admitting physician, it is her responsibility to follow the orders of the specialist previously treating him and monitor him as well. Dr. Connell noted that Dr. Cook has since changed her practice. Dr. Cook stated that she has found that when she is the physician discharging a patient, she makes sure that she contacts whoever is admitting that patient to go over the discharge orders. In closing, Mr. Lewis stated that he felt Dr. Cook's role in this patient's care was appropriate in following the orders that were communicated to her by the infectious disease specialist. Dr. Connell believed that Dr. Cook is knowledgeable and stated that it was clear that she has developed strategies to avoid this type of situation in the future.

MOTION: Dr. Connell moved to dismiss this case.
SECONDED: Dr. Lee
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Dr. Connell, Mr. Eckstrom, Dr. Goldfarb, Dr. Krishna, Dr. Lee, Dr. Mackstaller, Dr. Martin, Dr. Pardo, Ms. Proulx, and Dr. Schneider. The following Board Members were absent: Ms. Griffen and Dr. Petelin.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
5.	MD-06-0323A	A.M.	KENNETH M. FISHER, M.D.	12762	Refer to Formal Hearing.

Dr. Fisher was present with counsel, Mr. Calvin Raup. Dr. Fisher would not indicate that he understood the interview is not a full evidentiary hearing and by choosing the interview over a formal hearing he waived his right to a full evidentiary hearing, including the opportunity to question the medical consultant who may have reviewed his case. Dr. Martin stated the Board should remain consistent and entertained a motion to refer this case to formal hearing.

MOTION: Dr. Krishna moved to refer this case to Formal Hearing.
SECONDED: Dr. Connell
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

The meeting adjourned at 2:31 p.m.

Timothy C. Miller, J.D. Executive Director